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September 19, 2011

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

As the nation's first and largest specialty network of rehabilitation therapists in independent practice, PTPN and its members who function as small businesses are pleased to offer this statement to the Health Subcommittee of the House Committee on Ways and Means with respect to the September 20 hearing that will focus on expiring provisions of the Medicare payment system. PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. The network has more than 1,000 provider offices (including 3,500 physical therapists, occupational therapists and speech/language pathologists) in 23 states. PTPN contracts with most of the major managed care organizations in the nation, including insurers, workers' compensation companies, PPOs, HMOs, medical groups and IPAs. All members of PTPN must be independent practitioners who own their own practices.

As you proceed with your efforts to reform and ensure stability of the Medicare program -- particularly the Physician Fee Schedule -- we would urge you to be continuously mindful of the independent rehabilitation therapy providers and suppliers who function as small businesses and who are an important, integral element of our delivery system. PTPN members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. This is especially true because private healthcare payers base their payments on Medicare's fee schedules and policies as well. Most importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

PTPN comments on issues of relevance to the hearing and other pertinent Medicare issues address the following topical areas:

- Medicare per Beneficiary Therapy Caps
- Sustainable Growth Rate
- Curbing Overutilization of Therapy
- Electronic Health Records

Therapy Caps

In January 2012 the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. While the latter is our overwhelming preference and, in our view, the most sensible Medicare policy, at minimum the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

Unless Congress acts, the therapy caps will once again arbitrarily end Medicare's coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services once a beneficiary has received an artificial dollar amount of services (\$1,870) of services in an entire calendar year. This set amount is without respect to a patient's condition or the need for services or the use of services at other times during a calendar year for either the same or a different condition.

It applies to Medicare beneficiaries in all outpatient health care settings with the exception of outpatient hospital departments. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist's or physician's office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent¹ or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care to the more costly hospital setting which Medicare will pay for, or paying 100% of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002*. Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004

PTPN urges Congress to extend the exceptions process for 2-3 years and direct the Centers for Medicare and Medicaid Services (CMS) to prepare “an alternative payment method” which was envisioned by the Balanced Budget Act of 1997. Specifically, Congress should direct CMS to utilize the exceptions process to incentivize the collection and submission of quality information (e.g., **functional outcomes data**) which could be used to describe the type and amount of care that is needed by specified patients or groups of patients. Legislative language that would effect this policy is appended to the end of this letter.

Sustainable Growth Rate (SGR)

At the end of this year, a congressionally passed waiver of the statutory sustainable growth rate (SGR) formula, will expire. As a result, due to this flawed formula, CMS has announced in the proposed rule that the physician fee schedule update for CY 2012 will be negative 29.4%. Moreover, because of the cumulative nature of the formula, updates for the foreseeable future will be negative as well. Not only is the SGR an example of a government policy (legislation) that does not work, but it also illustrates that efforts of Congress to undo this mistake – in the absence of complete repeal – are only making a bad situation worse.

For years, providers and beneficiaries have been told by both political parties that they are committed to a permanent fix for this flawed formula. Yet, because of the cost of undoing the unintended budgetary consequences of legislation enacted by Congress, the Medicare program and the beneficiaries it serves are placed in jeopardy.

The Congressional Budget Office estimates that replacing the SGR with a payment based on the Medicare Economic Index carries a ten-year score upward of \$300 billion. The same solution could have been implemented seven years ago for about one-tenth of that cost. But more frightening is the finding that, if left unaddressed, repealing and placing SGR five years from now will carry the staggering score of \$600 billion.

It is time for Congress to “bite the bullet” and address this dysfunctional law with a permanent replacement. Therapists and physicians operate as small businesses and cannot – and should not -- be expected to participate in a program that provides no stability or predictability in terms of payment for services. Further, if Medicare reimbursement is reduced by 30%, thousands of private managed care contracts based on Medicare rates will also be cut, millions of all types of healthcare providers nationally, and certainly driving many out of business.

Obviously, the best approach is to have this accumulated debt addressed by the Joint Select Committee on Deficit Reduction. However, this appears more logical than likely. In the absence of such action, the responsibility will fall to the committees of jurisdiction – including Ways and Means -- to remedy this problem. It is important to keep in mind that **even if the Select Committee does address it, the effects of those actions are targeted for 2013-2021; meaning that the aforementioned 2012 drastic negative update (29.4%) will be implemented. Therefore, your committee must assume leadership** and address this profound policy problem either alone or in conjunction with the Select Committee.

If the Committee (and Congress) chooses the “kick the can down the sidewalk” approach, a 3-5 year period of stability and predictability is strongly encouraged during which alternative reimbursement methods currently being tested can be evaluated for implementation as acceptable replacements for the SGR.

Curbing Overutilization of Therapy

Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PTPN believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91%) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

Electronic Health Records

PTPN urges Congress to extend to non-physician providers the same incentives for providers to establish electronic health records. Non-physician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our network members provide an important and valuable service that should be coordinated and communicated electronically. What sense does it make to encourage an information superhighway, but only allowing a certain select type of car to drive on it? The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

House Ways and Means Health Subcommittee
September 19, 2011
Page five

Conclusion

In summary, the above-discussed issues have beneficial effects on the therapy providers, the patient, and the Medicare system in the following ways: Repealing the SGR has major impacts on the provider but secondary benefits for the patient; the therapy cap repeal (extending the exceptions process) is primarily a Medicare beneficiary issue; assisting non-physician providers in accessing health information technology is beneficial to both PTs and their patients, and to the degree to which it creates efficiencies, the Medicare program; the benefits of curbing overutilization inure specifically to the Medicare program.

On behalf of PTPN, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. Our organization is eager to continue to work with the Committee, Congress and CMS to help preserve and strengthen the Medicare program.

Sincerely,



Michael Weinper, MPH, PT, DPT
President/CEO

See attached ADDENDUM below:

Proposed Therapy Cap Alternative Exceptions Process Based on Submission of Quality and Outcomes Data

ADDENDUM

Proposed Therapy Cap Alternative Exceptions Process Based on Submission of Quality and Outcomes Data "The DCS Exception"

(a) BENEFICIARY CONDITION AND OUTCOMES DATA

1. **In General.** -- No later than January 1, 2012, the Secretary of Health and Human Services ("Secretary") shall in collaboration with national professional associations representing each therapy discipline (including physical therapy, speech-language pathology, and occupational therapy) and those associations that represent providers or suppliers who offer services to beneficiaries in need of such services implement an initiative to:
 - (a) identify general and discipline-specific data elements regarding patient condition, including severity of condition,
 - (b) develop general and discipline-specific patient assessment processes to collect such data,
 - (c) identify and measure appropriate indicators, such as age, illness, severity and settings, that may be used in assessing appropriate payment for services, and
 - (d) implement a data collection system ("DCS") using the above-referenced discipline-specific assessment tools that measure the quality and efficiency of therapy treatment.
2. **Sites.** --The Secretary shall ensure that the initiative includes a variety of geographic sites and practice settings including nursing facilities in which the therapy disciplines furnish services under Medicare Part B.

(b) SERVICES NOT SUBJECT TO PER BENEFICIARY CAP

1. **In General.** -- Any provider or supplier that furnishes outpatient therapy services to fee-for-service Medicare beneficiaries or outpatient rehabilitation services provided in a SNF under consolidated billing provision and submits claims to the Medicare program for such services, may voluntarily agree to participate in the DCS by submitting data on quality measures or patient outcomes to the Secretary.
2. Beneficiaries receiving treatment from a person or entity participating in the data collection initiative described in this paragraph shall not be subject to financial limitations under section 1833(g)(2) of the Social Security Act (42 U.S.C.1385l(g)(2)).

- (c) **REPORTS.** -- The Secretary shall report to the Congress on (a) the adequacy of the assessment processes in reflecting the quality and efficiency of therapy treatment, (b) identify or recommend alternative data elements and assessment processes that would reflect the quality and efficiency of therapy treatment, and (c) payment methods based on beneficiary need and effectiveness of rehabilitation as alternatives to the beneficiary therapy caps. The Secretary shall submit an interim report to the appropriate committees of the Congress no later than October 1, 2012, and a final report to such committees no later than April 1, 2013.